Assumptions and Evidence

There is community spread of SARS-CoV-2. Numbers are only estimate

Staff in long term care facilities (LTCF) work in multiple facilities

Cultural pressures require working with symptoms of upper and lower respiratory infections

There are multiple respiratory viruses still circulating

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Communication

- LTCF should communicate with physician, local health department, regulatory agency, families, staff and residents
- Immediately inform the local heath department and IDPH of symptomatic residents to determine if COVID-19 testing is indicated. Once a positive case is identified in a facility, no additional testing is needed in either residents or staff
- E-mail blasts, letters to residents, families, and staff, closed circuit communication, screen savers
- Post signage for hand hygiene and cough etiquette, ensure necessary supplies to accomplish these tasks are present at all entries and patient care areas. Notify all residents, staff, visitor and families of current situation
- Up to date scripts for receptionists, intake personnel
- Keep everyone up to date, and keep information up to date
- Transparency
- Communicate to staff how they will be supported when symptomatic

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Outbreak Definition in Long Term Care

- One lab confirmed case of COVID-19 and at least one case of COVID-like illness (CLI) with onsets within 14 days of each other
- NOTE: Once one positive case is identified, no additional testing is needed in either residents or staff

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Suggested Approaches I

- Processes and activities which increase residents' risk should be modified or suspended
- Stop large group congregate activities and provide alternatives (arrange in room dining or dining that maintains social distancing and activities, stop bingo, beauty shop, outside volunteer presentations, church, etc.)
- If not already being performed begin screening all residents and staff including temperature checks and use of checklists to identify symptomatic individuals
- Inform staff to stay home when sick insuring non-punitive practices during this period. Screen all staff prior to shift for temperature and respiratory symptoms. If present staff member should be sent home until symptoms resolve

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Suggested Approaches II

- Focus on decreased staff rotation and cohort staff to work with symptomatic residents whenever possible.
- Ensure staff are educated on and correctly performing hand hygiene, donning and doffing of PPE, and using appropriate products for environmental cleaning / disinfection.
- Ensure adequate supplies of PPE are easily accessible to staff.
- Identify additional isolation rooms limiting to single unit if possible, cohort like cases if necessary (e.g., influenza with influenza, COVID-19 with COVID-19, etc.).
- Ensure adequate testing supplies and masks are available for staff collecting specimens (for first resident being tested). Avoid aerosol generating procedures. If necessary use face and eye protection, N95 or respirator, close door and pull curtain. Wipe horizontal surfaces with EPA registered and approved product (List N products) after procedure. If supplies become scarce, follow CDC recommendations for crisis capacity use.

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Fever

- For staff: 100 F (37.8 C) per CDC
- For residents: Suggest continuing to use Revisited McGeer definitions (2012).
- 1. Single oral temperature 37.8 C (100 F)
- **OR**
- 2. Repeated oral temperatures 37.2 C (99 F) or rectal temperatures 37.5 C (99.5 F)
- **OR**
- 3. Single temperature 1.1 degree C (2 degrees F) over baseline from any site (oral, tympanic, axillary)

Stone et al., 2012

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Resident/Patient Management I

- All residents/patients should be screened by obtaining full set of vitals AND pulse oximetry every 8 hours (Q8 hours)
- If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory viral infection
  - Full Vitals AND pulse oximetry every 4 hours (Q4hours) {twice a shift}
  - Private Room or cohort with another symptomatic/positive patient
  - Maintain Standard, Contact and Droplet Precautions (including eye protection)
  - Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients
  - Positive or symptomatic patients should be given a surgical mask and encouraged to wear at all times
  - These residents/patients should be wearing a surgical mask when close contact with others is anticipated

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Resident/Patient Management II

- Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both Contact and Droplet transmission-based precautions.
- The isolation should be implemented by the healthcare member who discovers the symptoms pending a physician order.
- Residents with confirmed COVID-19 or displaying respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.)

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Resident/Patient Management III

- Symptomatic residents should only leave their room as required for medical procedures not available on site (i.e., dialysis, medical specialist appointment, and critical testing not available at the facility).
- If the resident is to leave room for these purposes the shortest route should be utilized and the immediate area/route to the exit/treatment areas should be cleared of all residents and unnecessary staff.
- Testing to rule out routine pathogens may be completed via rapid influenza testing and respiratory viral panels (Rhinovirus, RSV, etc.).

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Resident/Patient Management IV: Hospitalization

- Facilities should be able to accept COVID-19 residents from the hospital if clinically stable.
- New admissions (residents and families) should be notified if the facility has COVID-19 in the building.
- Determination to send the resident to the hospital should be based on the same criteria used for other illnesses.
- Those residents with severe illness requiring hospitalization should be transferred to the hospital with notification to EMS and the receiving hospital.
- Hospitals must be encouraged to communicate directly with LTCF during admission/discharge process.

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Healthcare Personnel Management : Asymptomatic

- All employees should promptly notify supervisor of any symptoms of illness in themselves or individual in their care.
- Provide symptoms report and allow temperature monitoring upon entry to work. All employees should be pre-screened for fever and symptoms prior to shift and every 4 hours (or once during shift if extended shifts are used).
- Perform hand hygiene on arrival at the facility, during the 5 Moments of Patient Care activities, and prior to going home.
- Employees may utilize extended use techniques with masks and eye protection when caring for residents.
- Asymptomatic staff do not need to be tested for SARS-CoV2 (cause of COVID-19)
- If employee has been tested and has a negative COVID-19 test and does NOT have symptoms, they may continue to work.
- Agencies of contract employees should be notified of risk and screen their staff to prevent transmission from facility to facility.
- Use limited and or consistent agency staff during the COVID-19 pandemic if possible.
- PPE should not be worn off affected units or areas unless approved as enhanced control measure.

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Healthcare Personnel Management : Symptomatic

- All employees should promptly notify supervisor of any symptoms of illness in themselves or individual in their care.
- Employee who are ill will exclude themselves from work environments and will seek the advice of their health care provider.
- Symptomatic staff do not require testing but, should be considered possible cases with work restrictions and isolation at home for a minimum of 7 days after onset and can be released after afebrile and feeling well (without fever reducing medications) for at least 72 hours.

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Personal Protective Equipment: No Facemasks

- **When No Facemasks Are Available, Options Include**
- Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.
- Designate convalescent HCP for provision of care to known or suspected COVID-19 patients.
- Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask.
- Consider use of expedient patient isolation rooms for risk reduction. (HEPA filtered fan to increase air movement)
- Consider use of ventilated headboards
- Last resort: HCP use of homemade masks

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

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Equipment Use, Cleaning, Disinfecting

- Dedicate medical equipment for patient care if at all possible
- Routine cleaning and disinfecting
- List N: EPA registered hospital grade disinfectant"...demonstrated effectiveness against viruses similar to SARS-CoV-2 (COVID-19) on hard non-porous surfaces."
- Wet contact times known by users
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly
- If no available EPA-registered products approved on EPA List N as emerging viral pathogen claim for SARS-CoV-2 (COVID- 19), products with label claims against **human coronaviruses** should be used according to label instructions

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

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RELEASING COVID-19 CASES AND CONTACTS FROM ISOLATION AND QUARANTINE

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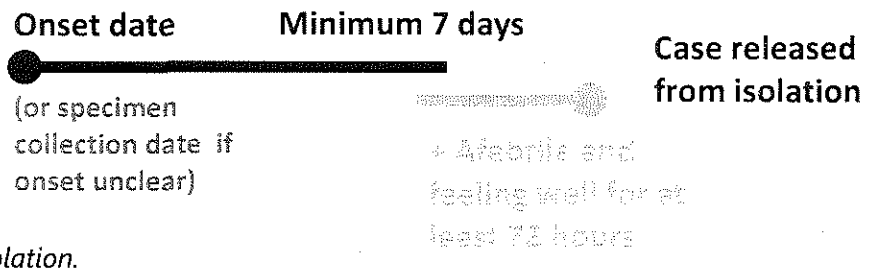
CASES

Must be isolated for a minimum of 7 days after symptom onset and can be released after afebrile and feeling well (without fever-reducing medication) for at least 72 hours.



Note: Lingering cough should not prevent a case from being released from isolation.

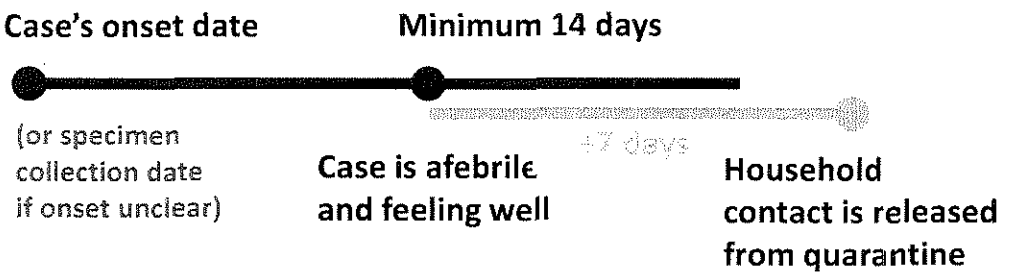
Examples:

- A case that is well on day 3 and afebrile and feeling well for 72 hours must remain isolated until day 7.
- A case that is still symptomatic on day 7, and symptoms last until day 12, cannot be released until day 15.

HOUSEHOLD CONTACTS

Must be quarantined for 7 days after the case has been afebrile and feeling well (because exposure is considered ongoing within the home) and for a minimum of 14 days.

If a household contact develops symptoms, follow directions for case



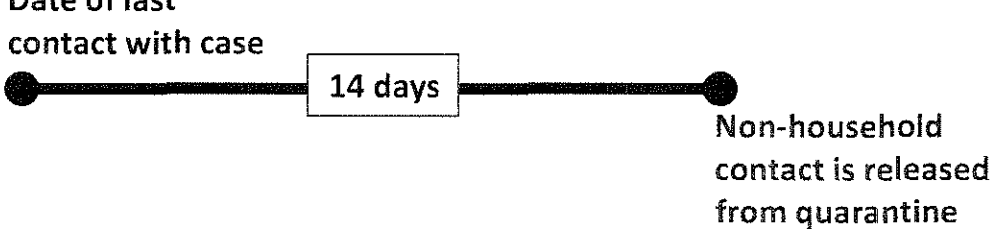
This means that household contacts may need to remain at home longer than the initial case.

Examples:

- A case is well 3 days after onset. The household contact must remain quarantined until day 14.
- A case is well 7 days after onset. The household contact can be released on day 14.
- A case is well 14 days after onset. The household contact can be released on day 21.

NON-HOUSEHOLD CLOSE CONTACTS

Must be quarantined for 14 days from the date of last contact with the case.



Interim guidance as of March 13, 2020. Subject to change.